Department of Public Health and Human Services MEDICAL ASSISTANCE	Section: RESIDENTIAL MEDICAL INSTITUTIONS Subject: Post-Eligibility Treatment of Income for Institutionalized Individuals

Supersedes: MA 904-3 (01/01/07)

References: 42 CFR 435.725 and .832; ARM 37.82.101, .1320

GENERAL RULE—An unmarried individual's gross monthly income (minus allowable deductions) must be applied toward the cost of his/her institutional care, if Medicaid is contributing to the cost of the institutional care. This budgeting process is known as “Step 2” of the institutionalized budgeting process. An institutionalized individual's incurment is budgeted according to a different method when Medicaid is not contributing to the cost of care. (See MA 904-6.) Allowable income deductions when Medicaid is contributing to the cost of the institutional care may include:

NOTE: Total deductions may not exceed the institutionalized individual's gross income.

1. up to $65 of gross earned income;

   NOTE: Blind/disabled work expenses do not apply in post-eligibility treatment of income.

2. a personal needs allowance of:

   a. up to $90 for a veteran or the spouse of a veteran who is receiving Veterans benefits; or

► b. $50 (or the amount of the individual’s remaining income at this point in the budget, if less than $50).

3. incurred medical or remedial care expenses of the institutionalized individual including health insurance premiums (see MA 703-1).

4. court-ordered child support actually paid (see MA 601-3);

5. court-ordered alimony actually paid (see MA 601-3); and

6. a home maintenance allowance.

► **NOTE:** When a community spouse enters an institution and Medicaid eligibility is determined for the (previous) community spouse, the CSIMA is countable income in the budget, and the (previous) community spouse is entitled to a home maintenance allowance, because s/he is treated as an individual.

AID AND ATTENDANCE

Veterans Administration Aid and Attendance (A&A) payments may be converted to a Veterans Pension payment of up to $90 per month after the third month of care for a veteran who:

1. is Medicaid eligible;

2. resides in a residential medical facility; and

3. has neither a spouse nor dependent child(ren).

The veteran will retain up to $90 of his/her Veterans benefit for his/her personal needs.

► **NOTE**: The veteran is <u>not</u> entitled to the $50 personal needs allowance in addition to the $90 allowance.

INCURRED MEDICAL EXPENSES

Certain medical expenses can be deducted from an individual's income when determining liability toward cost of care.

► **NOTE:** Incurred medical expense deductions are not allowed for nursing home expenses incurred prior to the individual establishing eligibility for Medicaid institutional coverage or incurred during an asset transfer penalty period.

Deductible medical expenses incurred prior to the initial month of Medicaid eligibility or entry into an institution,

whichever is later, include medical or remedial care expenses which:

a. were incurred during the three months prior to application or nursing home coverage request date;

b. were unpaid at the time of application or nursing home coverage request date;

c. are not payable by a third party, and

d. were not previously used to meet an incurment or to offset the individual's obligation toward cost of care in a previous month.

Incurred medical expenses are allowed for a maximum of three months or until expenses are paid in full, whichever comes first. Allowable medical expenses incurred prior to Medicaid application must be reported and verified during the time period in which they are eligible to be allowed as expenses. See MA 703-1 for limitations on medical expenses.

Deductible medical expenses incurred during Medicaid eligibility periods include the following expenses:

1. health insurance premiums (including Medicare);

2. medical expenses incurred while in the institution that are:

   a. prescribed by a physician;
   b. not Medicaid covered services;
   c. not payable by a third party; and
   d. subject to the limitations outlined in MA 703-1.

NOTE: Items such as eye drops, procedure gloves, wipes, etc., are included in the Medicaid payment to the nursing facility as part of Medicaid-covered services, and cannot be billed separately to the nursing home resident.

Medical expenses incurred after application must be reported in a timely manner (within 10 days of knowing of the expense).

HOME MAINTENANCE

The home maintenance allowance is the Medically Needy Income Level (MNIL) for one, and is allowed in the following situations:

1. for the month of entry, when the individual entered the facility from the community (including entering from a hospital stay, if the individual entered the hospital from the community) after the first day of the month; or

2. for up to six months when the individual is intending to return to the community (even if there are no verifiable housing expenses during the individual's institutionalization); or

   NOTE: A physician must certify that the individual will return home within six months of entry. This deduction is initially allowed for a maximum of three months of continuous stay in the facility (including the month of entry), with the possibility of a three-month extension, based on a renewed physician's statement in the third month of institutionalization. Intent and medical feasibility must be established upon entry into the facility. If an individual is discharged to return home (not for a visit, medical treatment, or vacation) and remains out of the facility for one full day or more, a new six-month period during which the home maintenance allowance is available may be established, if requested and accompanied by a new physician's statement.

3. for the month of discharge when the individual leaves the facility before the last day of the month to reestablish residence in the community.

►FAMILY CONTRIBUTION TO FACILITY

If a Medicaid applicant/recipient's family (or anyone else) pays an additional amount directly to the institution to upgrade the person from a semi-private to a private room, the additional payment is not considered in-kind income for shelter. Expenses paid to a residential medical facility are medical expenses.

►NOTICE

The Medicaid recipient or authorized representative must receive notice of the institutionalized individual's applicable deductions and liability toward cost of care. The institution must receive concurrent notice of the patient's liability toward cost of care only, even when the liability toward cost of care is zero.

PROCEDURE

Responsibility		ACTION
Applicant or Representative	1.	Complete HCS-250 or HCS-245 application; appear for an interview (if requested); provide required verification.
	2.	Request a preadmission screening (See MA 902-1).
Preadmission Screening Committee	3.	Provide the caseworker and the facility with SLTC-61,"Screening Determination", indicating whether the applicant's placement in the facility is authorized.
Eligibility Case Manager	4.	If placement is not authorized by the Mountain Pacific Quality Health Foundation, deny institutional coverage.
	5.	If placement is authorized and the person meets all other eligibility criteria, determine financial eligibility.
	6.	Document case file (include the SLTC-61, "Screening Determination", plus other non-financial and financial verifications).
	7.	Notify the applicant of the eligibility determination.
	8.	If eligible, notify the medical institution of the recipient's liability toward cost of care.

9. Transfer the case to the county where the medical institution is located, if requested by the recipient or authorized representative (see MA 103-1).

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